TEXAS Department of State Health Services

Local health departments should fax completed investigation form to regional DSHS office.
Regional DSHS offices should fax completed investigation form to 512-776-7616.

Legionellosis Investigation Report Form

NBS ID:

Patient's name: _____
Last First
Address: _____
City: _____ **County:** _____ **Zip:** _____
Phone 1: ( ) _____ **Phone 2:** ( ) _____
Date of birth: ___/___/___ **Age:** _____ **Sex:** ☐Male ☐Female ☐Unknown
Race: ☐White ☐Black ☐Asian ☐Pacific Islander ☐Native American/Alaskan ☐Unknown ☐ Other: _____ **Hispanic:** ☐ Yes ☐ No ☐ Unknown
Occupation:_____

Reported by: _____
Agency: _____
Phone: ( )_____**Date reported:** ___/___/___

Investigated by: _____
Agency: _____
Phone: ( ) _____
Email:_____
Investigation start date: ____/____/____

CLINICAL DATA

Date of symptom onset: ___/___/___ **Date illness ended**: ___/___/___
Outcome? ☐ Survived ☐ Died on: ___/___/___ ☐ Still ill ☐ Unknown
Hospitalized? ☐ Yes ☐ No ☐ Unknown
If yes, date of admission ____/____/____ Date of discharge ____/____/____
Name and location of hospital:_____
Physician:_____ **Phone:** ( )_____
Signs and symptoms (Check all that apply): ☐ Pneumonia ☐ Cough
☐ Myalgia (muscle pain) ☐ Headache ☐ Malaise ☐ Chest pain
☐ Chills ☐ Fever (Max temp:_____) ☐ Abdominal Pain ☐ Vomiting
☐ Diarrhea ☐ Other: _____

MEDICAL HISTORY

Does the patient have any underlying health conditions?
☐ Yes (check all that apply) ☐ No ☐ Unknown
☐ Current smoker (packs a day: _____) ☐ Past smoker
☐ Asthma ☐ Other chronic lung disease
☐ Diabetes ☐ Chronic kidney disease
☐ HIV infection ☐ Corticosteroid therapy
☐ Heart disease ☐ Liver disease
☐ Cancer ☐ Organ transplant recipient
☐ Other immunosuppressive condition: _____

LABORATORY DATA

Urine antigen test: Date collected: ____/____/____ Result: ☐ Positive ☐Negative ☐ Unknown

Culture: Date collected: ____/____/____ Specimen source: ☐ Lung biopsy ☐ Sputum ☐ Pleural fluid ☐ Blood ☐ Other:_____
Result: ☐ Positive ☐ Negative ☐ Pending ☐ Unknown If positive, species_____ serogroup:_____

Antibody test:
1st (acute) antibody titer:_____ Species / serogroup:_____ Date collected: ____/____/____
2nd (convalescent) antibody titer:_____ Species / serogroup:_____ Date collected: ____/____/____

Other legionellosis test: Test name: ☐ Nucleic acid assay (PCR) ☐ Direct fluorescent antibody (DFA) ☐ Other:_____
Date collected: ____/____/____ Specimen source: ☐ Lung biopsy ☐ Sputum ☐ Pleural fluid ☐ Blood ☐ Other:_____
Result: ☐ Positive ☐ Negative ☐ Pending ☐ Unknown If positive, species_____ serogroup:_____

TRAVEL HISTORY

In the 10 days before onset, did the patient spend any nights away from home (excluding healthcare settings)? ☐ Yes ☐ No ☐ Unknown
If yes, please complete the following table:

Accommodation name	Address, city, state, zip	Country	Room number	Arrival date	Departure date

A confirmed case has a compatible clinical history and meets at least one of the following laboratory criteria:
1) isolation (culture) of any *Legionella* species from lung tissue, respiratory secretions, pleural fluid, blood, or other sterile site
2) detection of *L. pneumophila,* serogroup 1, antigen in urine
3) fourfold or greater rise in antibody titer to *L. pneumophila*, serogroup 1, between paired acute and convalescent phase serum

Incubation period: Legionnaires' disease 2 – 10 days; Pontiac fever 5 - 72 hours.

OTHER EXPOSURE HISTORY **Is this case associated with an outbreak?** ☐ Yes, location:_____ ☐ No ☐ Unknown

In the 10 days before onset, did the patient visit or stay at a healthcare setting (e.g., hospital, rehab facility, clinic, dental office)?

☐ Yes ☐ No ☐ Unknown If yes, please complete the following table:

Type of healthcare setting	Type of exposure	Name of facility	Reason for visit	City	State	Date(s) of visit / admission	Date of discharge
☐ Hospital ☐ Rehab ☐ Clinic ☐ Dental ☐ Other:_____	☐ Inpatient ☐ Outpatient ☐ Visitor ☐ Employee ☐ Volunteer						
☐ Hospital ☐ Rehab ☐ Clinic ☐ Dental ☐ Other: _____	☐ Inpatient ☐ Outpatient ☐ Visitor ☐ Employee ☐ Volunteer						

If yes, was the facility a transplant center? ☐ Yes ☐ No ☐ Unknown

If yes, was the patient hospitalized or living at the healthcare facility for the entire 10 days before onset? ☐ Yes ☐ No ☐ Not applicable ☐ Unknown

In the 10 days before onset, did the patient visit or stay at a nursing home, assisted living facility or senior living facility?

☐ Yes ☐ No ☐ Unknown If yes, please complete the following table:

Type of facility	Type of exposure	Name of facility	City	State	Date(s) of visit / admission	Date of discharge
☐ Nursing home (with skilled nursing or personal care) ☐ Assisted living facility ☐ Senior living facility (without skilled nursing or personal care) ☐ Other:_____	☐ Resident ☐ Visitor ☐ Employee ☐ Volunteer					
☐ Nursing home (with skilled nursing or personal care) ☐ Assisted living facility ☐ Senior living facility (without skilled nursing or personal care) ☐ Other:_____	☐ Resident ☐ Visitor ☐ Employee ☐ Volunteer					

If yes, was the patient living at the facility for the entire 10 days before onset? ☐ Yes ☐ No ☐ Not applicable ☐ Unknown

In the 10 days before onset, did the patient get in or spend time near a whirlpool spa / hot tub / Jacuzzi? ☐ Yes ☐ No ☐ Unknown

If yes, where:_____ What dates:_____

In the 10 days before onset, did the patient use a nebulizer, CPAP, BiPAP or any other respiratory therapy equipment for the treatment of sleep apnea, COPD, asthma or for any other reason? ☐ Yes ☐ No ☐ Unknown

If yes, does the device have a humidifier? ☐ Yes ☐ No ☐ Unknown

What type of water is used in the device? ☐ Sterile ☐ Distilled ☐ Bottled ☐ Tap (well) ☐ Tap (city) ☐ Other:_____ ☐ None ☐ Unknown

In the 10 days before onset, did the patient have any other exposures to 'misty' water (fountains, misters, etc)? ☐ Yes ☐ No ☐ Unknown

If yes, what and where:_____ What dates:_____

In the 10 days before onset, did the patient have any exposures to soil (gardening, excavation, etc)? ☐ Yes ☐ No ☐ Unknown

If yes, what and where:_____ What dates:_____

In the 10 days before onset, did any remodeling or construction occur at or near the patient's home or work? ☐ Yes ☐ No ☐ Unknown

If yes, what and where:_____ What dates:_____

Comments

_____

_____